Sister Margaret Smith Centre

301 Lillie St. North
Thunder Bay, Ontario, P7C 0A6
Telephone: 807.684.5100
Fax: 807.622.1779
www.sjcg.net

Referral Package
and
Program Information
Adult Addiction Programs

October 2016

ST. JOSEPH'S CARE GROUP
SISTER MARGARET SMITH CENTRE
301 NORTH LILLIE ST.
THUNDER BAY, ONTARIO
P7C 0A6
FAX#- 807 622-1779

ADULT ADDICTIONS & PROBLEM GAMBLING TREATMENT REFERRAL FORM

Client Name: ________________________ DOB: ___________ Date: ___________________

Referent Name: _____________________________ Agency: ____________________________

System Case Manager (if applicable) : ____

Schedule of appointments with Case Manager: _______________________________________

Referral to the following services offered by Adult Addictions Programs:
(check all that apply)

Substance use Assessment [ ]
Explorations Group [ ]
Women's Support Group [ ]
Men's Support Group [ ]
OA Men's Breakfast Club [ ]
55+ Stepping Stones women's support group [ ]

Intensive residential [ ]
DBT Skills group [ ]
Concurrent screening [ ]
Family program [ ]
Gambling program [ ]
Stress management [ ]
Individual counselling for ________________ [ ]

Additional referrals made for client by Case Manager:

Balmoral WMS [ ]
Physician [ ]
Crossroads Centre [ ]
Ontario Works [ ]

Medical withdrawal [ ]
Balmoral groups [ ]
Hope Place [ ]
Mental health services- [ ]
(Specify)- ____________________

Client signature: Date:

____________________________________ ________________________

Counsellor signature:

____

PLEASE SEND THIS COMPLETED FORM WITH YOUR REFERRAL PACKAGE.

SISTER MARGARET SMITH CENTRE
ADULT ADDICTIONS PROGRAM
REFERRAL PROCESS FOR SUBSTANCE ABUSE PROGRAMS

STEP 1 ASSESSMENT

The MOHLTC approved **Admission & Discharge Criteria & Assessment Tools** package should be completed for all referrals for substance abuse services. The ***Admission & Discharge Referral & Decision Tracking Summary*** must be forwarded, in addition to the BASIS-32 scoring sheets. We also require the SMSC Adult Addiction Program ***Referral Package*** be completed with the client. Make sure the Treatment Referral Form is completed to identify the program options you are referring your client to. If you are unable to complete the assessment please contact Intake directly.

STEP 2 REFERRAL TO AN ADULT ADDICTIONS PROGRAM OPTION

The completed package is sent to **Intake for Adult Addictions** at the SMSC where it is reviewed based on the client admission criteria. Please include the completed Consent to Release Information form designating your agency so we can communicate information about the client as needed. Once the Intake team has reviewed all the documentation, they will contact the client and copy the referent with an appt time with a counselor or to set up an Intake appt. for Residential and/or Explorations group referrals.

STEP 3 ASSESS FOR WITHDRAWAL MANAGEMENT NEEDS

The expectation varies regarding the need for clients to be free from any alcohol or drug use (other than approved medications) depending on the program option they are requesting. If needed, clients may be referred to a withdrawal management program. Alternatives may be needed for the management of other withdrawal symptoms. These should be discussed with SMSC Intake.

STEP 4 ASSESS FOR STABILIZATION NEEDS

Some clients may require stabilization prior to participating in their choice of treatment option. Stabilization means readiness for the level of treatment and physically, mentally and emotionally stable. This can be done through community based services (case management, support group, medical or psychiatric services) and\or referral to a residential support program which offers stabilization services (ie Crossroads Centre). These should be arranged by the Case Manager in consultation with SMSC Intake.

STEP 5 ADMISSION TO THE TREATMENT OPTION

Once any pre-treatment requirements are met, the client will receive a letter which confirms their Admission date for their program choice, and includes an Information sheet outlining anything they may need to know about the program.

SISTER MARGARET SMITH CENTRE-
ADULT ADDICTIONS PROGRAM

INTENSIVE RESIDENTIAL TREATMENT CLIENT ADMISSION CRITERIA

1. **MENTAL HEALTH -** The client must be capable of living in a group situation and participating in an intensive group treatment process. Prescribed psychoactive medications for mental health conditions must have been reviewed by a psychiatrist or physician and pre-approved for treatment by Intake prior to admission.

2. **MEDICATION** - All medications, both prescribed and non-prescribed, must be reviewed and approved by Intake prior to admission. If the client arrives with any medications not previously approved, they will have to be reviewed by the Smith Centre's medical practitioner prior to taking the medication. In the case of life enhancing medications i.e. Dilantin, Nitroglycerin, the client must have medical clearance prior to admission.

   PLEASE NOTE: Benzodiazepines require written physician approval prior to the client being given an admission date. Due to Health & Safety concerns for both clients and staff, **Narcotic Drugs** (ie oxycodone, morphine, codeine preparations) need to be reviewed by our medical consultants and a specialized plan developed for storage and delivery. (Categories as defined by the Office of Controlled Substances, Health Canada- see Appendix 1- Compendium of Pharmaceuticals & Specialties- 2010).

3. **METHADONE-** We accept clients on a Methadone program, **only** if they have been stabilized on the program for at least 2 months and on the same dosage for 2 weeks. They must have a clear screen (other than prescribed meds) for a week prior to admission. All methadone prescriptions must be transferred to a local pharmacy or clinic.

4. **PHYSICAL/COGNITIVE ISSUES–** Any physical health or cognitive impairments must be assessed for their interference with the client's ability to participate in the treatment program. Special dietary needs, limits to activity, memory, processing ability or other impairments may be able to be accommodated; however, the Smith Centre must be aware of them prior to admission.

5. **VIOLENCE -** Clients with current or previous charges or a history involving violence (physical or sexual) will be assessed for potential harm to staff and other clients, prior to acceptance of the referral. This is a co-ed facility with Men, Women and Youth Services treatment programs in the same building. We reserve the right to refuse admission to someone who could put the other clients and staff at risk.

6. **CONFIRMED TREATMENT DATE – Once we have all the information requested, a tentative Treatment date may be given in order to secure access to Pre-treatment services. The client must meet all the Pre-admission requirements listed for them to follow in order to receive a Confirmed Treatment date. A Treatment Date Confirmation form must be signed and returned to Intake. If these steps are not followed the client will likely lose their treatment date.**

THUNDER BAY INTEGRATED ADDICTION AND MENTAL HEALTH SERVICES
CONSENT TO OBTAIN / RELEASE INFORMATION

The protection of your privacy and the delivery of high quality care is our priority. In order to best serve you, a group of service providers, all committed to the protection of your privacy, are working together to support your decisions regarding your care. With your permission, we will share information with each other and with other agencies to support you in developing a plan of care that is designed to support your choices and decisions.

The following agencies are part of a service system which is designed to support you in reaching your personal goals.

Thunder Bay Counselling Centre _______
Addiction Services, Thunder Bay, ON

St. Joseph's Care Group _______
Addiction & Mental Health Services
Thunder Bay, ON

Alpha Court Community Mental Health and _______
Addiction Services, Thunder Bay, ON

Crossroads Centre Inc. _______
Thunder Bay, ON

Children's Centre Thunder Bay _______
New Experiences Program
Thunder Bay, ON

Dilico Anishinabek Family Centre _____
Mental Health and Addictions Services
Thunder Bay, ON

If you are in agreement for the above named agencies and related programs to share assessment, treatment and case management information, please indicate your authorization by **initialing beside each relevant agency**.

In addition, there may be cause to share your personal health information with other care providers and agencies to support you in meeting your personal goals. If you are in agreement for the agencies listed below to obtain/release information with the authorized agencies in Thunder Bay Integrated Addiction and Mental Health Services please sign beside each agency indicating your authorization.

Consent to release/request information from the persons/agencies below:	Date	Signature
1. **EMR (electronic medical records)TBRHSC&SJCG**	____________	________________________
2. ________________________________	____________	________________________
3. ________________________________	____________	________________________
4. ________________________________	____________	________________________

Having read and understood this form, I hereby authorize the identified agencies of Thunder Bay Integrated Addiction and Mental Health Services to Release/Request Information to/from each other and to/from the persons/agencies listed above. I also understand that I can withdraw my consent in writing at any time and that I can restrict the nature and type of information shared. This consent is considered valid for a period of six (6) months from the date of signature when it will be reviewed and renewed as required.

____
Name (Please Print) D.O.B. (dd/mm/yr) Signature

______________________________ ______________________________
Reviewed and Witnessed By Date

Substitute decision maker ____
(Please Print)

Signature:____________________ Date:________________ Relationship:________________

Thunder Bay Addiction and Mental Health Services

Guidelines for Completing Form

- Clinician / Case Manager will review the Consent to Obtain/Release Information with the client and address any questions/concerns prior to obtaining a signature
- Clinician / Case Manager will review the Consent to Service prior to obtaining client signature
- Copy of the Consent to Service and Consent to Obtain/Release Information will be filed on the clients' record
- The receiving agency conducting the initial intake will also provide a copy of their agency's privacy statement

ST. JOSEPH'S CARE GROUP
301 LILLIE ST. N.
THUNDER BAY, ONTARIO
P7C OA6

SISTER MARGARET SMITH CENTRE
ADULT ADDICTION PROGRAMS
CLIENT REFERRAL PACKAGE

MEDITECH #: _______________(SJCG)

CLIENT INFORMATION FORM	REFERENT INFORMATION
FIRST NAME: MIDDLE NAME:	DATE OF REFERRAL:
LAST NAME: LAST NAME AT BIRTH:	REFERRING AGENCY:
DOB:DD/MM/YEAR AGE:	NAME OF REFERENT:
GENDER: [ ] MALE [ ] FEMALE [ ] OTHER	EMAIL:
HEALTH CARD # : PROVINCE:	AGENCY ADDRESS:
STREET ADDRESS: CITY: PROVINCE: POSTAL CODE: CONTACT BY MAIL: YES [ ] NO [ ] NFA- [ ]	POSTAL CODE: PHONE: FAX#:
HOME PHONE # : CALL ALLOWED: YES [ ] NO [ ] MESSAGE ALLOWED YES [ ] NO [ ] OTHER PHONE #: CALL ALLOWED: YES [ ] NO [ ] MESSAGE ALLOWED YES [ ] NO [ ]	CLIENT TYPE – PLEASE CIRCLE 1. Client- Alcohol/Drug 2. Client- Alcohol/Drug/Gambling 3. Client- Gambling 4. Family member of Alcohol/Drug Client 5. Family member of Alcohol/Drug/Gambling Client 6. Other- Non-Addictions
CURRENT RESIDENCE (IF DIFFERENT FROM ADDRESS LISTED ABOVE) PHONE #:	ETHNICITY- ETHNIC OR CULTURAL IDENTITY: PRIMARY- SECONDARY- STATUS #-
EMERGENCY CONTACT: RELATIONSHIP: PHONE #:	PREFERRED LANGUAGE: NEED FOR TRANSLATOR?

SECTION 1- CATALYST ADMISSION INFORMATION
PLEASE CIRCLE THE NUMBER IN EACH SECTION THAT BEST FITS:

1. TREATMENT MANDATED\REQUIRED BY:

1. None
2. Choice between treatment or jail
3. Condition of probation/parole
4. Child Welfare Authority
5. Condition of employment
6. Condition of school
7. Condition of family
8. Other _______________

2. LEGAL STATUS:

1. No problem
2. Awaiting trial\sentencing
3. On probation- Start date: ____________ (DD/MM/YEAR) End date:______________(DD/MM/YEAR)
4. On parole
5. Incarcerated
6. Other _______________

3. RELATIONSHIP STATUS:

1. Married/partnered/common-law
2. Single (never married)
3. Widow or widower
4. Separated or divorced

4. EMPLOYMENT STATUS:

1. Employed full-time (includes self-employment)
2. Employed part-time
3. Unemployed (looking for work)
4. Student\ retraining
5. Disabled (not working)
6. Not in labour force
7. Retired

5. HIGHEST LEVEL OF EDUCATION:

1. No formal schooling
2. Some primary school
3. Primary school
4. Some high school
5. Completed high school
7. Some college
8. Completed college
9. Some university
9. University degree

6. INCOME SOURCE:

1. Disability insurance (WSIB)
2. Employment
3. Employment insurance
4. Family Support
5. None
6. ODSP
7. Ontario Works
8. Other Insurance
9. Retirement
10. Other __________________________

7. PARENTING (CUSTOM FIELD)

1. Yes, with 1 or more child aged 0-6 years
2. Yes, with no children aged 0-6 years
3. Children in care of others
4. No children

SUBSTANCE USE & GAMBLING HISTORY

PRESENTING PROBLEM SUBSTANCES:

	SUBSTANCE USED	FREQUENCY IN LAST 30 DAYS- CIRCLE ONE	
MAJOR SUBSTANCE		1. Did not use 2. 1-3 times monthly 3. 1-2 times weekly	4. 3-6 times weekly 5. Daily 6. Binge
1ST OTHER SUBSTANCE		1. Did not use 2. 1-3 times monthly 3. 1-2 times weekly	4. 3-6 times weekly 5. Daily 6. Binge
2ND OTHER SUBSTANCE		1. Did not use 2. 1-3 times monthly 3. 1-2 times weekly	4. 3-6 times weekly 5. Daily 6. Binge

OTHER SUBSTANCES USED IN PAST 12 MONTHS: (circle all the ones that apply)

1. Alcohol
2. Amphetamines & other stimulants
3. Barbiturates
4. Benzodiazepines
5. Cannabis
6. Cocaine
7. Crack
8. Ecstasy
9. Glue & other inhalants
10. Hallucinogens
11. Heroin\ Opium
12. Methamphetamines (Crystal Meth)
13. Other Psychoactive drugs
14. Over-the-counter codeine products
15. Prescription opioids
16. Steroids
17. Tobacco
18. Unknown
19. None

IS GAMBLING IDENTIFIED AS A PROBLEM? YES [ ] NO [ ]

IF YES, WHAT IS THE TREATMENT PLAN: ____

GAMBLING ACTIVITIES ENGAGED IN THE PAST 12 MONTHS:

1. Bingo - live/TV/radio
2. Slot machines
3. VLT's/ other gaming machines
4. Casino- Card/Table Games
5. Non-Casino Card/Table Games
6. Horse races-live/off-track
7. Sports betting (including Pro Line)
8. Lottery tickets
9. Instant win/scratch tickets (i.e. break open, pull tab, Nevada strips)
10. Internet Gambling
11. Gambling with Stocks/Options/Commodities/Real estate
12. Betting on games of skill i.e. pool, pitching pennies
13. Betting on the outcome of events
14. Other ______________________
15. None
16. Unknown

HEALTH STATUS/PROBLEMS

Visual impairment: **YES [ ] NO [ ]**
Hearing impairment: **YES [ ] NO [ ]**
Mobility/ physical impairment: **YES [ ] NO [ ]**

Pregnant: **YES [ ] NO [ ] POSSIBLE [ ]**

Non-medical intravenous drug use: [ ] Never injected
[ ] Injected prior to one year
[ ] Injected in last 12 months

Number of overnight hospitalizations in last 12 months for physical problems: ____________________

Reason for most recent hospitalization:____

Diagnosed with a mental health problem by a mental health professional:

-within the past 12 months- **YES [ ] NO [ ]**

-within lifetime- **YES [ ] NO [ ]**

-most recent diagnosis**-** ____

Hospitalized for a mental health problem?

-within the past 12 months- **YES [ ] NO [ ]**

-within lifetime- **YES [ ] NO [ ]**

Received counselling/support/treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?

-currently- **YES [ ] NO [ ]**

-within the past 12 months- **YES [ ] NO [ ]**

-within lifetime- **YES [ ] NO [ ]**

-name of current service provider: ____

-contact information for service provider: ____

Prescribed medication for a mental health problem:

-currently- **YES [ ] NO [ ]**

-within the past 12 months- **YES [ ] NO [ ]**

-within lifetime- **YES [ ] NO [ ]**

HEALTH Conditions/Problems

Please check all that apply:

[ ] allergies- environmental- specify-___________
[ ] allergies- food- specify ___________________
[ ] blood pressure problems
[ ] cancer
[ ] chronic pain
[ ] diabetes
[ ] Eating disorders (anorexia,bulimia, Over eating)
[ ] HIV/AIDS
[ ] heart disease
[ ] Hepatitis A
[ ] Hepatitis B
[ ] Hepatitis C
[ ] history of head injuries/concussion
[ ] history of seizures/epilepsy
[ ] jaundice
[ ] kidney disease
[ ] lice/scabies
[ ] liver disease
[ ] menstrual/menopausal difficulties
[ ] pancreatitis
[ ] respiratory
[ ] STD (syphilis, gonorrhea, chlamydia, herpes)
[ ] stomach/gastrointestinal problems
[ ] thyroid problems
[ ] tuberculosis

Provider of Primary Health care (doctor, nurse practitioner, health clinic): ___________________________

Contact information for provider of health care: ____

PRESCRIBED DRUGS

Drugs currently prescribed

On Methadone or opioid substitute: **YES [ ] NO [ ]** Prescriber:___________________________

Prescribed Drug	Prescriber & Phone #	Prescription Details

NOTES ON HEALTH STATUS:

SECTION 2- ADDITIONAL INFORMATION- ALL REFERENTS COMPLETE:

REFERRAL INFORMATION:

1. What circumstances have made the client request treatment at this time?

____

____

____

2. Describe the nature of your involvement with the client.

____

____

____

____

3. What supports are you providing or able to provide on a pretreatment basis?

____

____

____

____

4. What supports does the client have access to in the community? What supports/services has the client accessed to date? (If the client has not accessed services please explain why)

____

____

____

SYMPTOMS / TREATMENT HISTORY:

1. Please put an X by all **addiction related** symptoms the client has experienced:

[ ] feeling sluggish, without energy
[ ] headaches
[ ] rapid heart rate
[ ] passing out
[ ] flashbacks / tracers
[ ] seeing / hearing things not really there
[ ] poor concentration
[ ] chronic cough
[ ] Other (specify)____________________

[ ] disrupted sleep
[ ] nausea / vomiting
[ ] shakiness, unsteady hands
[ ] blackouts
[ ] sweating
[ ] poor memory
[ ] nose bleeds

2. Has the client previously tried to quit or cut down on their substance use or gambling?

No__________ Yes_______ How many times ?_____________________________________

3. What were the circumstances that caused the client to make changes with his/her use during these times?

____

____

4. What has been the longest period of maintained change? ___________________________________

5. What did the client find helpful during those periods?

____

____

6. Where does the client place him/herself on the continuum of use? (Please determine for each substance used)

Drug # 1___________	Drug # 2___________	Drug # 3___________	Drug # 4___________
[ ] No Use	[ ] No Use	[ ] No Use	[ ] No Use
[ ] Social/recreational use	[ ] Social/recreational use	[ ] Social/recreational use	[ ] Social/recreational use
[ ] Habitual Use	[ ] Habitual Use	[ ] Habitual Use	[ ] Habitual Use
[ ] Problematic use	[ ] Problematic use	[ ] Problematic use	[ ] Problematic use
[ ] Abuse	[ ] Abuse	[ ] Abuse	[ ] Abuse
[ ] Dependence	[ ] Dependence	[ ] Dependence	[ ] Dependence

7. What is the client's current substance use or gambling goal?:
   - [ ] quit all substance use/gambling
   - [ ] cut down on ______________________
   - [ ] maintain abstinence
   - [ ] make no changes
   - [ ] other______________________

8. Previous addiction treatment- No previous treatment attempts- [ ]
   Yes, **FILL IN TABLE BELOW**

PLACE	WHEN	TYPE OF TREATMENT	COMPLETE?

9. What did the client find most helpful about their past treatment experience(s)?

____

____

____

10. What did the client find most challenging about their past treatment experience(s)?

____

____

NOTES ON SYMPTOMS/TREATMENT HISTORY:

EMOTIONAL HEALTH:

PLEASE ANSWER YES OR NO AND PROVIDE INFORMATION ON HOW THE CLIENT HAS COPED AND WHAT SUPPORTS HAVE BEEN UTILIZED

CONCERN	EXPERIENCED IN LAST 90 DAYS	EXPERIENCED IN LIFETIME	SUPPORTS/COPING SKILLS USED
Anxiety- tension, nervousness fears / phobias			
Depression- grief, losses, isolation			
Eating disorders- starving on purpose, binging/purging			
Sexual abuse / sexual assault			
Abuse- physical, emotional, mental			
Suicide- suicidal thinking, attempts, self-harm behaviour			
Cognitive- difficulty tracking , concentrating, focusing			
Anger- assaults, aggressive behaviour			
Other trauma (eg. deaths, accidents, other traumatic events)			

NOTES ON EMOTIONAL HEALTH **(INCLUDING MENTAL HEALTH /DIAGNOSIS DETAILS)**

FAMILY/SUPPORTS:

1. What community is the client originally from?____

2. Childhood Experiences:

[ ] Substance abuse of mother/father
[ ] Witness to violence
[ ] Emotional, physical or sexual abuse
[ ] Taken into care
[ ] Neglect
[ ] Divorce/separation of parents
[ ] Death of a parent
[ ] No concerns

3. How does the client describe the relationship with his/her family of origin?

____

____

4. Relationship Experiences:

[ ] Never been in a relationship
[ ] Affairs
[ ] Mental health issues of partner
[ ] Difficulties talking about feelings
[ ] Violence/abuse
[ ] Solid/supportive relationship

5. If the client is currently in a relationship, does the partner struggle with any addiction issues?

____

____

6. Does the client have any children? [ ] Yes [ ] No
If yes, who has custody of the children? What is the nature of the relationship with the children?

____

____

NOTES ON FAMILY/SUPPORTS

ECONOMIC / EMPLOYMENT / EDUCATION:

1. Current or last occupation?______________________________

2. Does the client have EAP in the workplace?______________________________

3. If not working, what is the client's source of income?______________________________

4. If attending school, which program? ______________________________

5. Does the client have a history of learning disabilities or problems? YES [ ] NO [ ]
   If yes, what type:______________________________

How does the client best learn new information? (e.g. verbally, observing, participating, hands-on, reading etc)

____

NOTES ON EDUCATION / EMPLOYMENT-

LEGAL:

1. Any current charges? YES [ ] NO [ ]

2. If yes, what are they?______________________________

   When is the next court date?______________________________

3. If on probation or parole…

   What charges is the client on probation for?______________________________

   Probation or parole officer's name:______________________________

   Contact Information:______________________________

4. Past Offenses (check <u>all</u> that apply):
   [ ] theft / possession of stolen property
   [ ] drug charges
   [ ] weapons offenses
   [ ] robbery
   [ ] arson
   [ ] impaired driving
   [ ] parole / probation violations
   [ ] forgery
   [ ] burglary, break & enter
   [ ] assault
   [ ] sexual assault / incest
   [ ] willful damage / mischief
   [ ] murder / manslaughter, criminal negligence causing death
   [ ] other – (specify):______________________________

NOTES ON LEGAL-

GOALS FOR TREATMENT

1. What are the client's goals for treatment?

2. What does the client see as important areas to explore in treatment in order to achieve those goals?

3. What group experiences has the client had to date? (what did they like/dislike?)

4. What is the client's availability for treatment?

5. What does the client see as the biggest barrier or potential barrier for attending a treatment program?

STRENGTHS AND RESOURCES

1. What gives the client hope?

2. What does the client see as his/her personal strengths?

PRE-TREATMENT PLAN FOR CLIENT-

Pre-treatment service suggested to client	Yes \ No	Agency Suggested
Withdrawal management services (detoxification)		
Stabilization prior to treatment- supportive housing, individual counselling, attend meetings.		
Medical services- medication management, physical assessment, medical procedures.		
Psychiatric services- psychological or psychiatric assessment, medication stabilization.		
Other (specify)________________________		

SUMMARY NOTES

______________________________ ______________________________
Signature of Client Date

______________________________ ______________________________
Signature of Counsellor Date

Intake\Referral Package – OCT. 2016

Leisure Wellness Screening Questionnaire

Part 1

1. What do you do for fun?

2. What do you do to relax and wind down? (e.g. leisure activities)

3. What do you do for social activities?

4. What types of gambling activities do you engage in?

5. How many times a week do you gamble? (Note: explore all activities including lottery tickets, Nevada tickets, bingo and casino).

6. Do you ever go to the casino or other gambling locations? (e.g. internet, lottery kiosk etc).

7. How much time do you spend on these activities?

8. How much money do you spend on gambling?

Part 2:
*Note: Please complete part 2 ONLY if gambling is identified as an issue

To help us to evaluate your gambling behaviour, please answer the questions below as truthfully as you are able from your own experience.

1. Sometimes I've felt depressed or anxious after a session of gambling.
Yes, that's true. No, I haven't.

2. Sometimes I've felt guilty about the way I gamble.
Yes, that's so. No, that isn't so.

3. When I think about it, gambling has sometimes caused me problems.
Yes, that's so. No, that isn't so.

4. Sometimes I've found it better not to tell others, especially my family, about the amount of time or money I spend gambling.
Yes, that's true. No, I haven't.

5. I often find that when I stop gambling I've run out of money.
Yes, that's so. No, that isn't so.

6. Often I get the urge to return to gambling to win back losses from a past session.
Yes, that's so. No, that isn't so.

7. Yes, I have received criticism about my gambling in the past.
Yes, that's true. No, I haven't.

8. Yes, I have tried to win money to pay debts.
Yes, that's true. No, I haven't.